State of New Jersey
DEPARTMENT OF BANKING AND INSURANCE
PO BOX 325
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Commissioner

NEW JERSEY STATE DEPT OF BANKING AND INSURANCE
LIFE AND HEALTH DIVISION
MANAGED CARE BUREAU
POST OFFICE 325
TRENTON, NEW JERSEY 08625

SELECTIVE CONTRACTING ARRANGEMENT
TRIENNIAL RENEWAL APPLICATION

In accordance with New Jersey Administrative Code (N.J.A.C.) 11:4-37.4 (g), a carrier shall apply for triennial renewal of the Department's approval of its Selective Contracting Arrangement at least 60 days prior to the expiration of the previous three-year approved period. This time frame reflects a reasonable period for the insurance carrier to file for renewal and a 60 day period for the Departments of Banking and Insurance and Health and Senior Services to review the renewal application. Once approved, the Selective Contracting Arrangement's renewal date will revert to the original date.(ie.,) the next renewal date will be 6 years from the original date of approval.

Attached you will find the renewal application. The renewal application fee is $1,500 payable to the New Jersey Department of Health and Senior Services. There is no fee required by the Department of Banking and Insurance.

To apply for renewal:
Send one complete copy of the renewal application to:

Managed Care Bureau
Life and Health Division
New Jersey Department of Banking and Insurance
20 West State Street-11th Floor
Post Office Box 325
Trenton, NJ 08625-0325

Send a second complete copy with the required fee to:

Office of Managed Care
Department of Health and Senior Services
John Fitch Plaza
Post Office Box 360
Trenton, New Jersey 08625

SELECTIVE CONTRACTING ARRANGEMENT
TRIENNIAL RENEWAL AFFIDAVIT

The undersigned, being duly sworn according to law upon his/her oath deposes and says:

I, _____in my capacity
(Affiant's full printed name-no initials)

_____, on behalf of
(Affiant's title)

_____, which is located at
(Name of Insurance Company)

_____
(Street and City where the insurance company is located)

do hereby make application for the renewal of the selective contracting arrangement between the above-named insurance carrier and _____PPO,
(Name of the PPO Network)

whose authority shall otherwise expire on _____
(Expiration date and year)

I do hereby certify on this _____day of _____, 19___, under penalty of perjury that I am a principal officer of the above-named insurance company, and that all statements made herein and in the renewal request form attached hereto and incorporated herein are true and correct to the best of my knowledge and belief.

_____
(Signature of Affiant)

SELECTIVE CONTRACTING ARRANGEMENT
TRIENNIAL RENEWAL APPLICATION

PART I

Please answer all of the following questions. If an item is not applicable, please mark it as nonapplicable or NA and explain in your view why it is not applicable. Please number answers in accordance with the item number. Attach all documentation and explanations.
When completed, and no later than 30 days prior to the date of expiration of the Selective Contracting Arrangement Approval, submit this application and supporting documentation.

_____
_____
__

1. Insurance Company-Full Name and Address of the Insurance Carrier (Applicant)
(Please indicate any name changes, changes in ownership and the dates)

_____
_____
__

The Name and Telephone Number of the Principal Contact Person
(may be used on mailing lists that are distributed to the public upon request)

_____
_____
__

2. PPO-Full Name, Address, Telephone number of the PPO. (If an HMO network is serving as the PPO, in this SCA, please indicate that here also.) Please include the name of the Prinicpal Contact Person and their telephone number for each PPO.

_____
_
_____
_

Hospital/ Medical Network:

_____
_____
__

Perscription Drug Network:

_____
_____
__

Vision Care Network:

_____
_____
__

Dental Care Network:

_____
_____
__

Behavioral Health Network(Mental Health and Substance Abuse):

_____
_____
__

Home Health Services Network:

_____
_____
__

Laboratory Network:

_____
_____
__

3. Identify which market you are currently serving. Large group (>50 employees), Small group (2-50 employees), and / or individuals. Have you withdrawn from any market in which you were previously approved? If so please indicate the date.

_____
_____
_____
___

4. List, in reverse chronological order, and include a copy of changes which have been made in the past three (3) years to the articles of incorporation, shareholder agreement, bylaws and management agreements (If not already reported). If you need additional space, please attach separate sheets of paper.

_____
_____
_____
___

5. List any new PPO Board Members, and Insurance Company managed care PPO Officers, Directors responsible for managed care.

_____
_____
_____
___

6. Please enclose any current organizational charts for the PPO and the managed care division of the insurance carrier.

7. As of the date of this form and December 31 of the prior two years, list the number of grievances or complaints made during the year and the number outstanding.

	#Complaints Made	#Complaints Outstanding
Current_____:	_____	_____
12/31	_____	_____
12/31	_____	_____

8. Have any changes been made to the provider contracts in the past three years?
YES___ NO___

If yes, enclose the new agreement indicating the deletions and additions.
_____
_____
_____

9. Have any changes been made to any marketing or advertising materials in the last three years? If yes, please enclose copies. YES____ NO____

10. Please provide actual membership by rating status at year ending 12-31-yr..

	N-3	N-2	N-1	CURRENT TO DATE YR (N)
EE				
EE & SP				
EE & CH				
FAMILY				

11. Have any changes been made to the employee handbook and /or certificate/evidence of coverage?
If yes, please enclose new editions.
YES___ NO___

12. Please enclose the most recent audited financial statement for both the insurance carrier and the PPO; and the most recent unaudited financial statement for the PPO(s)
(monthly, quarterly, or annual).

13. Have you made any changes to your plan designs in the last three years?
YES___ NO___

If so, please enclose an updated benefit differential calculation and certification. See the attached summary chart.

14. Please list the SCA plan income by calendar year:

N-3	N-2	N-1	Current To Date Yr (N)

SCA Premium _____

SCA Incurred Claims _____

SCA Number of Claims _____

15. Please list the counties (if < 21) in which you are currently operating:
_____
_____
_____
_____
____

SELECTIVE CONTRACTING ARRANGEMENT
TRIENNIAL RENEWAL

PART II

Complete the following questions with attachments as appropriate. If you are unable to answer any questions, or if they don't apply, please explain why.

1. Provide a list of the names and addresses (city and state) of enrolled employers as of December 1997 and a list of the same as of December 1996. Also include number of enrolled employees for each enrolled employer. (Attach a separate sheet)

PART III: PROVIDER NETWORK INFORMATION

1. Complete Table 3 and 6

2. Submit a Provider Directory or list of all providers by name, address, phone number and by county by speciality.

3. A description of the geographical service areas in which the health benefits plan is to be offered.
_____
_____
_____

4. A description of the manner in which covered services and other benefits may be obtained by covered persons using the selective contracting arrangement;

_____
_____
_____

5. A description of the criteria and method used to select preferred providers including any credentialing plan.

_____
_____
_____

6. A description of any provisions which allow covered persons to obtain covered services from a health care provider that is not a preferred provider.

_____
_____
_____

7. Current enrollment by county with break-outs for:
   sex-male/female
   age-under 18/over 18

PART IV: MEDICAL MANAGEMENT

QUALITY ASSURANCE

1. Please submit a description of Q/A program (1 page summary)

2. Staff organizational chart including names.

3. Flow chart of activities

In accordance with NJAC 11: 4-37, a description of the quality assurance program at a minimum shall include:

a. a clear description of how quality of care will be monitored and controlled.
b. the criteria used to define and measure quality
b. criteria used to determine the success or failure of the quality assurance program
d. description of the staff and their qualifications that will be responsible for the quality assurance program.

UTILIZATION REVIEW

1. Please submit a description of the U/R program (1 page summary)

2. Organizational chart including the names

3. Flow chart of activities

In accordance with NJAC 11: 4-37 a description of the utilization review program shall include:

a. a description of the criteria and methods to be used in utilization control, particularly the criteria for determining over and under utilization and

b. a description of the mechanisms for evaluating the success or failure of the utilization review program.

EMERGENCY CARE/URGENT CARE

1. A description of the EMS program (1 page summary)

2. Flow chart of activities.

Please refer to the Health Care Quality Act N.J.S.A. 26:2S and N.J.A.C. 8:38A.1 et seq. for Health Standards. The Department of Health and Senior Services (DHSS) suggests that the applicant schedule an appointment with DHSS staff at (609) 633-0660 to discuss the standards.